Individual Revocation of PHI Authorization

I, ______________________________ (patient's name), am notifying __________________________ (name) ___________________________ (title) CPS Dental, Inc. located at 11 Hanover Square, 8th Floor, New York, NY 10005, that I am revoking my authorization dated ___________________________ (date) for the release of my health information for the assistance in claim administration on my behalf.

I understand that I cannot revoke any action already taken by CPS Dental, Inc. in reliance upon my authorization prior to the date of this revocation.

___________________________________ ___________________________

Patient's Signature Date

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Print Patient's Name